STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 45819, Olympia, WA 98504

March 21, 2019

Highland Court Operating Company LLC
Highland Court Memory Care
1704 Melody Ln
Port Angeles, WA 98362

RE: Highland Court Memory Care License #2378

Dear Administrator:

The Department completed a follow-up inspection of your assisted living facility on March 18, 2019 for the deficiency or deficiencies cited in the report/s dated February 6, 2019 and found no deficiencies.

The Department staff who did the follow-up inspection:
Phan Pham, Nurse Surveyor

If you have any questions please, contact me at (360) 664-8421.

Sincerely,

Chris Cornell

Chris Cornell, Field Manager
Region 3, Unit D
Residential Care Services

STATE OF WASHINGTON
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
AGING AND LONG-TERM SUPPORT ADMINISTRATION
PO Box 45819, Olympia, WA 98504

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MAR 11 2019
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REGION 3

Statement of Deficiencies	License #: 2378	Completion Date
Plan of Correction	Highland Court Memory Care	February 6, 2019
Page 1 of 11	Licensee: Highland Court Operating Company LLC	AMENDED

You are required to be in compliance at all times with all licensing laws and regulations to maintain your assisted living facility license.

The department has completed data collection for the unannounced on-site full inspection on 1/29/2019 and 1/31/2019 of:

Highland Court Memory Care
1704 Melody Ln
Port Angeles, WA 98362

The following sample was selected for review during the unannounced on-site full inspection : 7 of 40 current residents and 0 former residents.

The department staff that inspected the assisted living facility:

Tracy Kouri, BSW, MBA, ALF Licensor
Claudia Machado, RN, MSN, Complaint Investigator

From:

DSHS, Aging and Long-Term Support Administration
Residential Care Services, Region 3, Unit D
PO Box 45819
Olympia, WA 98504
(360)664-8421

As a result of the on-site full inspection the department found that you are not in compliance with the licensing laws and regulations as stated in the cited deficiencies in the enclosed report.

Chris Cornell — Residential Care Services
Feb 26 19 — Date

I understand that to maintain an assisted living facility license I must be in compliance with all the licensing laws and regulations at all times.

[signature] — Administrator (or Representative)
3/1/19 — Date

WAC 388-78A-2305 Food sanitation. The assisted living facility must:
(1) Manage food, and maintain any on-site food service facilities in compliance with chapter 246-215 WAC, Food service;

This requirement was not met as evidenced by:
Based on observations and interview, the facility failed to ensure that the person in charge had knowledge of proper food storage. This failure placed forty of forty Residents at risk for food borne illness.

Findings

On 1/29/19 at approximately 12:10 p.m., the walk-in refrigerator in the facility's kitchen, had the following items with the dates written on the containers:

Cooked ham: 1/20/2019
Salisbury steak with gravy and onions: 1/22/19
Taco meat: 1/20/19
Tomato soup: 1/22/19

During observations of the kitchen on 1/30/19 at approximately 12:15 p.m., all four items listed above remained in the walk-in.

During interview on 1/30/19 at 12:30 p.m. with Staff F, Cook, Staff F stated that he was uncertain of how long ready to eat foods could be kept in the refrigerator. Staff F further stated that the Kitchen Manager was working out of town and that Staff F was in charge.

During exit on 1/31/19 at approximately 5:00 p.m. Staff A, Administrator was informed of the findings.

Refer to WAC 246-215-02105 for more information.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Highland Court Memory Care is or will be in compliance with this law and / or regulation on (Date) 3/11/19. In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

I understand that to maintain an assisted living facility license, the facility must be in compliance with the licensing laws and regulations at all times.

Administrator (or Representative) — Date: 3/1/19

WAC 388-78A-2630 Reporting abuse and neglect.
(1) The assisted living facility must ensure that each staff person:
(a) Makes a report to the department's Aging and Disability Services Administration Complaint Resolution Unit hotline consistent with chapter 74.34 RCW in all cases where the staff person has reasonable cause to believe that abandonment, abuse, financial exploitation, or neglect of a vulnerable adult has occurred; and

This requirement was not met as evidenced by:
Based on interview and record review the facility failed to notify the Department's Complaint Resolution Unit (CRU) for six of six sample residents (Resident #1, Resident #5, Resident #8, Resident #9, Resident #10, and Resident #11) in a timely manner related to Resident's falls with injury and Residents with incidents and patterns of Resident to Resident altercations. This failure placed the sample Residents and all other facility Residents at risk for injury and unmet care needs.

Findings include...

Falls with injury:

Resident #5 (R#5) admitted to the facility on [redacted]18, with diagnosis that included, but were not limited to, [redacted].

The facility's incident report dated [redacted]19, described an incident where staff found R#5 on the floor in his room. The report stated: "Assessed for injuries and moved Resident carefully so his head was not on the table when he started to fall more into the table. EMS called for wellness check due to Resident not being responsive and hitting his head. Resident started to vomit, ... resident transported to OMC for further evaluation. Vital Signs: B/P (blood pressure - 59/39; Pulse - 82; Resp - 16; Temp 96.8"

A review of R#5's progress note from 1/3/19 noted that R#5 had been admitted to OMC on

[redacted]19. No documentation was found that indicated that the facility contacted CRU Hotline after R#5 sustained an injury after an alleged un-witnessed fall that resulted in transport and admission to the hospital.

Resident #8 (R#8) admitted to the Memory Care on [redacted]18 with diagnosis of, but not limited to [redacted].

During record review of the facility's incident and accident reports, an incident dated 11/25/18 read: staff saw R#8 lying face down on the dining room floor. "R#8 had skin tear on right hand, abrasion on left cheek, left eye swollen shut, bump on forehead, swelling on forehead and both hands, bruise on both hands and right upper leg and left upper arm."

During record review of R#8's progress notes, a progress note dated 11/27/19 read: "R#8's forehead and right side of her face continue to be swollen."

A progress note dated 12/19/18 written by Staff C, Registered Nurse read: "R#8 marked by six falls. The last one on 11/25/18 resulting in significant injury.

During interview on 1/30/19 at approximately 2:30 p.m., Staff B, Resident Care Manager stated that she did not call these incidents in to CRU Unit and that she was not aware that she needed to.

Resident to Resident Altercations:

Resident #1 (R#1) admitted to the Memory Care on [redacted]/18 with diagnosis of, but not limited to [redacted].

During record review on 1/29/19, R#1 had the following progress notes related to resident to resident altercations:

On 10/31/18: " no amount of re-direction was successful. R#1 yelling at another resident."

On 11/1/18: "R#1 had an altercation with roommate." R#1 had yelled at roommate and grabbed her.

On 1/2/19: "R#1 had an altercation with " R#1 grabbed another resident and started to shake her while yelling at her.

Resident # 9 (R#9) admitted to the Memory Care on [redacted]/18 with diagnosis of, but not limited to [redacted].

During record review of the facility's incident and accident reports, the following resident to resident altercations were reviewed:

On 12/8/18: "Heard R#9 yelling at three separate residents, saw R#9 slap and push a resident. Heard R#9 yelling at another resident and saw her hit that resident. Heard R#9 yelling at a different resident and saw her slap and push that resident."

On 12/22/18: Staff saw R#9 try to take a residents walker pulling it away from the resident and slammed it into the residents left upper arm.

On 1/6/19: "R#9 got into altercation with resident slapped him."

Resident #10 (R#10) admitted to the Memory Care on [redacted]18 with diagnosis of, but not limited to [redacted].

During record review on 1/29/19, of the Assisted Living's incident and accident reports, the following resident to resident altercations were reviewed:

On 12/4/18: R#10 hit a resident's face and pushed her against the wall.

On 1/6/19: R#10 got into an altercation with another resident. R#10 swung at the resident but missed.

Resident #11 (R#11) admitted to the Memory Care on [redacted]18 with diagnosis of, but not limited to [redacted]

During record review on 1/29/19, of the Assisted Living's incident and accident reports, the following resident to resident altercations were reviewed:

On 10/29/18: "Heard R#11 screaming." Another resident stated that R#11 pushed her.

On 1/12/19: "Staff walked by after hearing yelling from R#11's room. Upon entering the door staff saw that R#11 and another resident were taking swings at each other and yelling."

During exit interview on 1/30/19 at approximately 5:00 p.m., Staff A, Administrator stated that these incidents were not reported to the CRU Unit. Staff A stated that she was not aware that these incidents should be reported.

Plan/Attestation Statement

I hereby certify that I have reviewed this report and have taken or will take active measures to correct this deficiency. By taking this action, Highland Court Memory Care is or will be in compliance with this law and / or regulation on (Date) 3/11/19 . In addition, I will implement a system to monitor and ensure continued compliance with this requirement.

I understand that to maintain an assisted living facility license, the facility must be in compliance with the licensing laws and regulations at all times.

Administrator (or Representative) — Date: 3/1/19

WAC 388-78A-2660 Resident rights. The assisted living facility must:
(1) Comply with chapter 70.129 RCW, Long-term care resident rights;

RCW 70.129-140 Quality of life -- Rights.
(1) The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This requirement was not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure that seven of seven Residents (Resident #7, Resident #8, Resident #12, Resident #13, Resident #14, Resident #15 and Resident #16) in the assisted dining room received care and services in a dignified manner. This failure violated the Residents rights to a dignified dining experience.

Findings include...

The memory care had an assisted dining room. On 1/29/18 at approximately 11:30 a.m., during entrance interview, Staff B, Resident Care Manager stated that this dining room was used for Residents who require cues and reminders with meal time and Residents who need feeding assistance from staff.

The observations of the assisted dining room were done on 1/30/18 and 1/31/18 during breakfast and lunch.

During observations on 1/30/19 at approximately 12:25 p.m., R#7, R#8, R#12, R#13, R#14 and R#16 were seated in the dining room. The Residents food was not served until 1:05 p.m.

At 1:08 p.m. Staff G, caregiver began to feed R#7 and R#13. Staff G, then stopped feeding the Residents to check his work communication device. Staff G continued to feed R#13 and did not return to feeding R#7.

At 1:09 p.m. Staff J , Medication Technician came into the assisted dining room and administered liquid morphine orally to R#7. This process took approximately 30 seconds. Staff J then left the dining room. No staff were feeding R#7.

R#7 yelled, "help" at 1:15 p.m. Staff G then began to feed R#7 and continued to feed R#13.

At 1:25 p.m. R#7 closed her eyes and tilted her head forward. Staff G told R#7 to wake up but R#7 was unable to stay awake to finish her meal.

At 1:15 p.m., Staff D, Activities Director, came and began to feed R#12.

At another table, R#14 had finished his meal and grabbed R#16's plate. R#16's plate had a bite out of it. R#14 began to eat the food. No one offered a fresh plate for R#14.

Staff D and Staff G stopped feeding Residents to check their work communication devices two times.

At 1:20 p.m. Staff H switched with Staff D and began to feed R#12, Staff D left the dining room. Then at 1:21 p.m., Staff H left the assisted dining room. No staff were feeding R#12.

At 1:24 p.m. R#15 arrived at the assisted dining room. R#15 grabbed a handful of food off of R#8's plate. Staff G moved to sit by R#15. R#8 was not offered a fresh plate of food. R#8 continued to eat from the plate of food that R#15 had touched.

At 1:27 p.m., Staff H came back and began to feed R# 12 and R#13.

At 1:28 p.m. Staff G and Staff H started talking to one another. No one was interacting with the Residents.

During observations on 1/31/2019, R#7, R#8, R#12, R#13, R#14 and R#15 were seated at approximately 8:55 a.m. The Residents food was not served until 9:25 a.m.

Staff G was feeding R#12 and R#13. Staff G stopped feeding the Residents and checked his work communication device two times.

Staff I, Caregiver, was feeding R#15. Staff I stopped feeding R#15 and checked her work communication device two times.

At 9:31 a.m., Staff J, administered liquid morphine orally to R#7. This process took approximately 30 seconds.

At 9:40 a.m. R#7 closed her eyes and tilted her head down. Staff D, told R#7 to wake up. R#7 was unable to finish her meal.

At 9:45 a.m., R#8 and R#14 were done eating. R#8 and R#14 were using their forks and attempting to get more food from their empty plates. Staff G and Staff I were talking to one another. Residents were not offered more food. Residents were not taken out of the dining room

until 10:10 a.m.

On 1/31/19 at approximately 10:20 a.m., Staff I stated that she gave the morphine to the R#7 in the dining room all the time.

During record review of R#7's Medication Administration Record, physician order for Morphine read: PRN (as needed) for pain.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 3/1/19

WAC 388-112A-0610 Who is required to complete continuing education training each year, how many hours of continuing education are required, and when must they be completed?
(2) Assisted living facilities.
(b) Long-term care workers exempt from certification under RCW 18.88B.041 must complete twelve hours of continuing education by their birthday each year.

This requirement was not met as evidenced by:
Based on interview and record review the facility failed to have a system in place to ensure staff completed twelve hours of continuing education within the required twelve month period (birthday to birthday) for two of six sample Staff (Staff E and Staff J). This failure placed residents at risk of being cared for by unqualified staff.

Findings include...

During a review of sample staff records conducted on 1/29/19 the following staff did not have required continuing education training on file:

Staff E was hired on 9/1/16, she worked with vulnerable adults for 125 weeks and 5 days as of 1/29/19. A review of employee records showed that Staff H had no documentation of completing the required annual twelve hours of continuing education for long-term care workers.

Staff J was hired on 5/2/17, she worked with vulnerable adults for 91 weeks as of 1/29/19. A review of employee records showed that Staff J had no documentation of completing the required annual twelve hours of continuing education for long-term care workers.

On 1/29/19, Staff A, Administrator, reported that she reviewed the staff file for Staff E and Staff J. Staff A reported that neither Staff E or Staff J had completed the entire twelve hour requirement for continuing education for caregivers.

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Administrator (or Representative) — Date: 3/1/19

WAC 388-78A-2610 Infection control.
(1) The assisted living facility must institute appropriate infection control practices in the assisted living facility to prevent and limit the spread of infections.
(2) The assisted living facility must:
(d) Provide all resident care and services according to current acceptable standards for infection control;

This requirement was not met as evidenced by:
Based on observation and interview the facility failed to ensure five of five Staff, (Staff D, Staff G, Staff H, Staff I and Staff J), provided resident care and services according to the current acceptable standards of infection control for all facility Residents. This failure placed each facility Resident at risk for cross contamination, infection and decreased health and well-being.

Findings include...

On 1/29/18 at approximately 11:30 a.m., during entrance interview, Staff B, Resident Care Manager stated that the facility had a separate, smaller dining room that was used for Residents who require cues and reminders during meal time and for Residents who needed feeding assistance from staff.

The observations of the assisted dining room were done on 1/30/18 and 1/31/18 during breakfast

and lunch. During the dining observations, facility staff were providing assistance with feeding tasks.

During observations on 1/30/19 at approximately 12:25 p.m., R#7, R#8, R#12, R#13, R#14 and R#16 were seated in the assisted dining room. Residents received meals at 1:05 pm and began to receive staff assistance.

At 1:08 p.m. Staff G, Caregiver, began to assist R#7 and R#13. Staff G, was observed seated between the Residents and would provide food to R#7 and then provide food to R#13. During the meal service, Staff G was observed touching the Resident's plated food, his work communication device and clothing. Staff G did not wash his hands after touching the communication device and clothing as he provided personal care for multiple Residents.

At 1:15 p.m., Staff D, Activities Director, arrived and began to provide feeding assistance for R#12. Staff D began to provide food to R#12. Staff D was not observed to wash her hands prior to assisting R#12. During the meal service, Staff D was observed touching the Resident's plated food, her work communication device and clothing. Staff D did not wash her hands after touching potentially contaminated surfaces (communication device and the clothing).

At another table, R#14 had finished his meal and grabbed R#16's plate. R#14 began to eat R#16's food, was not re-directed by facility staff and was allowed to continue eating from R#16's plate.

At 1:20 p.m. Staff H Caregiver, began to provide feeding assistance for R#12. Staff H was not observed to wash his hands prior to providing meal assistance.

At 1:24 p.m. R#15 arrived at the assisted dining room. R#15 grabbed a handful of food off of R#8's plate. Staff G moved to redirect R#15 and then sat with R#15. Facility caregivers did not offer R#8 a fresh plate of food. Facility caregivers allowed R#8 to continue eating from the contaminated plate of food.

At 1:27 p.m., Staff H re-entered the dining area and sat between R#12 and R#13. Staff H, was observed to provide food to R#12 and then provide food to R#13. During the meal service, Staff H was observed touching the Resident's plated food, his work communication device, the Residents and his clothing. Staff H did not wash his hands after touching his communication device and other potentially contaminated surfaces.

During observations on 1/31/2019, R#7, R#8, R#12, R#13, R#14 and R#15 were seated at approximately 8:55 a.m. The Residents food was not served until 9:25 a.m.

Staff G was feeding R#12 and R#13. Staff G stopped feeding the Residents and checked his work communication device twice. During the meal service, Staff G was observed touching the Resident's plated food, his work communication device, the Residents and his clothing. Staff G did not wash his hands after touching his communication device and his clothing as he provided personal care for multiple Residents.

Staff I, Caregiver, was feeding R#15. Staff I stopped assisting R#15 and checked her work communication device two times. During the meal service, Staff I was observed touching the

Resident's plated food and her work communication device. Staff I did not wash her hands after touching her communication device as she provided personal care for R#15.

During the exit interview on 1/31/19 at approximately 4:10 p.m., the findings were provided to Staff A, Administrator, and Staff B, Resident Care Coordinator. Staff A stated that the facility had not considered staff handling the communication devices as a possible infection control issue.

Plan/Attestation Statement

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Administrator (or Representative) — Date: 3/1/19